DIFP provides these checklists in an effort to assist the HMOs. The check list should help assure that nothing is missing from the access plan. However, the checklists are a minimum representation of the items the Department considers when reviewing HMO access plans. They are in no way an exhaustive or complete statement of all requirements and provisions that might be applicable to any specific access plan. **Please refer to the statues and regulations for exact wording of requirements or prohibitions. The language within the Missouri Statutes and Regulations always prevails over the checklists.**

Company Name: _____

HMO NETWORK ACCESS

REVIEW REQUIREMENTS	CITATION	SUMMARY	Location in submitted information
Cover letter		All managed care plans offered by the HMO, including each product's name and type.	
		A chart indicating the populations served by the HMO and the Missouri counties in which the HMO is currently serving those populations.	
Written Portion		The HMO's procedures for making referrals within and outside its network.	
		The HMO's process for monitoring and assuring on an ongoing basis the sufficiency of the network's) to meet the health care needs of enrollees.	
		The HMO's methods for assessing the health care needs of enrollees and their satisfaction with services.	
		The HMO's methods of informing enrollees of which plan's services and features, including but not limited to each plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.	
		The HMO's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, for enrollees using ancillary services, including social service and other community resources, and for ensuring appropriate discharge planning.	
		The HMO's process for enabling enrollees to change primary care professionals.	
		The HMO's proposed plan for providing continuity of care in the event of contract termination between the HMO and any of its participating providers, in the event of a reduction in service area or in the event of the HMO's insolvency or other inability to continue operations. The description shall explain how enrollees shall be notified of the contract termination, reduction in service area or the HMO's insolvency of other modification or cessation of operations, and transferred to other health care professionals in a timely manner.	

		The most recent copies of all Network Provider Directories, including vision, behavioral health, pharmacy, chemical dependency and substance abuse or any other provider directories produced by subcontractors.		
	354.442.1(14)	The provider directories include: names, addresses, phone numbers for **ALL** participating providers, including board certifications where applicable.		
		If additional information is included, it complies with Missouri Law.		
		A written triage, treatment and transfer protocol for Emergency Medical Services.		
		Home Health Providers Chart		
		Measures are in place for timely access to appointments with **ALL** providers in Exhibit A.		
			Routine care within 30 days	
			Routine care with symptoms within 5 business days.	
			Urgent care within 24 hours	
			Emergency care available 24/7	
			Obstetrical care 1st, 2nd trimester within 1 week	
			Obstetrical care 3rd trimester within 3 days	
			Obstetrical care emergency available 24/7	
			Mental Health care-same as all other providers and 24/7 telephone access to a licensed therapist.	
		Demonstration or statement that the entire network is available to all enrollees along with a description of any network management practices that affect enrollees' access to all participating providers.		
		Employer specific networks-demonstration that group contract holder agreed in writing to the different or reduced network.		
		Listing of product names used to market the managed care plans.		
		Policies and procedures to assure that enrollees have access to providers not addressed in Exhibit A without unreasonable delay.		
		Information regarding network hospitals which utilize non-network services providers i.e. radiologists, anesthesiologists, pathologists, laboratories (or other hospital-based service providers) as follows:		
			Names and addresses of participating facilities where this occurs.	
			Identification of which specific hospital-based services are not contracted at the hospital..	
			Method of payment for the non-network services and/or enrollee's financial obligation.	
			Copy of disclosure provided to enrollees (including POS enrollees) regarding the hospital and the enrollee's possible financial obligation.	
		All changes and corrections noted in the 2007 access plan have been oncorporated into the 2008 access plan.		
		All changes related to new legislation have been oncorporated, if applicable.		

Check List for Affidavit in lieu of Data Submission		Must fall into one of the following categories:		
			Medicare + Choice	
			NCQA	
			JCAHO	
			URAC	
			Other	
		In effect on March 1, 2008 and accreditation date is listed on accreditation certificate.		
		Product name specified for the acredited managed care plan.		
		Form number of the health venefit plans listed and/or approved.		
		Affidavit is signed and notarized.		
		Copy of accreditation certificate identifying the accredited entity.		